

Northwest Center for Outcomes Research in Older Adults: A VA HSR&D Center of Excellence



Medical Centers - Seattle, WA & Portland, OR

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Seattle, WA & Center for Health Research (Kaiser Permanente), Portland, OR*

Performance Evaluation of Community-Based Outpatient Clinics

Community-based outpatient clinics (CBOCs) have been established by VA medical centers around the country to improve access to care and reduce cost for veterans in primary care settings. From 1995 to 1998, VHA approved more than 230 CBOCs and by the end of FY98, there were 139 CBOCs providing health care to veterans. In order to learn about the characteristics and performance of the rapidly growing number of CBOCs, the Under Secretary for Health requested that the Health Services Research and Development Service, through its Management Decision and Research Center, conduct a system-wide evaluation of CBOCs. Drs. Michael Chapko, Matt Maciejewski and Ashley Hedeon, along with Dr. John Fortney at the Little Rock VA and Dr. Steve Borowsky at the Minneapolis VA, recently completed the first evaluation of CBOCs.

A national CBOC Performance Evaluation Committee was convened to develop a set of CBOC characteristics and CBOC performance measures by which CBOCs

would be categorized and evaluated. Performance of these facilities was evaluated according to six domains: Access, Cost, Mental Health, Quality of Care, Patient Satisfaction, and Utilization. Data for this evaluation was collected at the facility-level and patient-level in a variety of ways. CBOCs were directly surveyed to obtain information about their characteristics and patient-level data was obtained from the National VA Outpatient Customer Satisfaction Survey to learn about patient satisfaction with care (HSR&D, 1999). In addition, clinical and administrative data from the Austin Automation Center and the new VA cost accounting system (Decision Support System or DSS) were used to generate estimates of patient utilization and costs. Finally, medical record reviews were conducted on a sample of patients to evaluate quality of care differences between CBOC and VA medical center (VAMC) patients (HSR&D, 2000). The basic research questions were:

♦ Is there a difference in performance between CBOCs and

VAMC primary care clinics?

♦ Do some types of CBOCs have better performance than others?

Two sets of comparisons were made in this performance evaluation: 1) CBOC patients v. patients in VAMC primary care clinics and 2) CBOC comparisons of three types (VA-Staffed CBOC patients v. Contract CBOC patients, Urban CBOC patients v. Rural CBOC patients, Patients in Old CBOCs v. Patients in New CBOCs). VA-staffed CBOCs are facilities directed operated by the parent VAMC. Contract CBOCs are private clinics contracted by VA medical centers under a capitated payment system to provide primary care services to eligible veterans. Contract and VA-Staffed CBOCs are expected to reduce VA costs and improve access because they provide primary care services and are located closer to veterans' homes (GAO, 1999). Old CBOCs are defined as facilities established in FY95, FY96 or FY97, while new CBOCs are defined as facilities established in FY98.

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Emblem: "Soul Catcher" ...a Northwest Coast Indian symbol used to ward off spirits that brought physical or mental illness. Artist: Marvin Oliver.

All comparisons were evaluated in case-mix adjusted, multivariate regressions that controlled for patient characteristics, such as age, race, gender, marital status, and percent service connected. Separate multivariate analyses compared VA-Staffed to Contract CBOC patients, Rural to Urban Patients, and Patients in New and Old CBOCs. The basic findings in the CBOC/VAMC patient comparisons are listed below:

- ◆ CBOC patients reported higher levels of satisfaction on seven of the eight Customer Service Standards (CSS) on the National Outpatient Customer Satisfaction Survey, though these differences were often small for most CSS categories. The most substantial difference was in higher satisfaction with access due to fewer reported problems. The seven Standards include Access/Timeliness, Patient Education/Information, Preferences, Emotional Support, Coordination of Care (overall), Coordination of Care (Visit), Courtesy, and Specialty Care Access.
- ◆ CBOC patients were less likely to report that one provider or team was in charge of their care, but did not report more problems with coordination or care on the CSS measures.
- ◆ CBOC patients had substantially more primary care stops and were more likely to be seen within 20 minutes of their scheduled appointments. While they had significantly fewer specialty care stops, they reported no greater problems gaining access to specialty care.
- ◆ Overall, CBOC patients did not differ in number of inpatient days or inpatient admissions. CBOCs treated a similar proportion of their patients for mental health problems and were equally timely in providing outpatient mental health follow-up following inpatient psychiatric treatment.
- ◆ CBOC patients had higher average primary care direct costs than patients seen in VAMC primary care clinics, in terms of cost per primary care visit and primary care cost per patient.
- ◆ The greater primary care costs were offset by lower ancillary costs for CBOC patients so that average total direct costs per patient were lower in CBOCs than in VAMC primary care clinics.
- ◆ CBOC patients had a substantially shorter average estimated one-way travel distance from their residences to the CBOCs (15 miles) than to the affiliated Parent VAMCs (56 miles).
- ◆ CBOCs had a lower percent of high priority veterans (priority levels 1 and 2) residing within a 30-mile radius who do not use VA primary care than did the Parent VAMCs.

◆ CBOCs are meeting the performance objectives set for them and veterans are receiving reasonable access to care and equal or better care when compared with VAMC primary care clinic patients. CBOCs appear to generate greater access to care and lower total cost per patient compared to the affiliated Parent VAMCs, as well as greater satisfaction and lower utilization of specialty care. These comparisons are based upon a small number of CBOCs (18-34, depending on the performance measure) and are not generalizable, but CBOCs may be a valid and promising approach for providing primary care to veterans.

The results from the VA-Staffed/Contract CBOC, Urban/Rural CBOC, and New/Old CBOC comparisons are presented next:

- ◆ Patients in VA-Staffed CBOCs had more primary care stops, more specialty stops, were more likely to be assigned a mental health diagnosis, and had shorter waiting time for follow-up following hospitalization than Contract CBOC patients.
- ◆ CBOC patients in urban CBOCs had greater primary care costs on a per visit and per patient basis than patients in rural CBOCs.
- ◆ CBOC patients in new CBOCs had greater primary care costs on a per visit and per patient basis than patients in old CBOCs.
- ◆ Patients at rural, new and Contract CBOCs had a greater reduction in travel distance than patients at urban, old and VA-Staffed CBOCs.

These analyses suggest that CBOCs have different utilization, access, and cost patterns, depending on the type of CBOC examined. It should be noted that Contract CBOCs were excluded from all cost comparisons. More research is needed to understand which of the three general sources of resource use differences drives the results found here - resource intensity per visit, use rate, and case-mix differences. CBOCs may provide the VA with a viable way to improve access to primary care in an outpatient setting, while reducing cost and/or improving quality of care.

References:

General Accounting Office, Veterans' Affairs: Progress and Challenges in Transforming Health Care, 1999, HEHS-99-109.

Health Services Research and Development Centers of Excellence in Little Rock, Minneapolis, and Seattle. CBOC Performance Evaluation: Performance Report 1: Measures Based on Austin Automation Center and Patient Survey Data. 1999.

Health Services Research and Development Centers of Excellence in Little Rock, Minneapolis, and Seattle. CBOC Performance Evaluation: Performance Report 2: Cost and Access Measures. 2000.

**The following abstracts will be presented
at the HSR&D Service 18th Annual Meet-
ing, March 22-24, 2000, Washington DC**

**Determinants of Alcohol Advice or Treat-
ment Among At-Risk Drinkers in the Out-
patient Setting: Results from the ACQUIP
Study**

Marcia Burman, MD, Mary McDonell, MS, Stephan Fihn, MD, MPH and Katharine Bradley, MD, MPH VA Puget Sound Health Care System, Seattle, WA

Objective: Randomized controlled trials have demonstrated that brief counseling interventions by primary care providers improve health outcomes in at-risk drinkers. However, the majority of at-risk drinkers never receive such advice and little is known about factors that lead primary care providers to counsel patients about their drinking. We examine rates of alcohol-related advice and treatment reported by male at-risk drinkers who receive primary care in the VA, and identify factors associated with at-risk drinkers' reports of not receiving any alcohol-related advice or treatment in the past year.

Methods: We surveyed patients followed at seven geographically diverse VA General Internal Medicine Clinics participating in the VA Ambulatory Care Quality Improvement Project (ACQUIP). At-risk drinkers, identified using a validated augmented CAGE questionnaire, were sent the ACQUIP Drinking Practices Questionnaire (DPQ) which includes the Alcohol Use Disorders Identification Test (AUDIT) and three questions about alcohol-related advice or treatment. Other data collected included demographic characteristics, socioeconomic status, patient reports of health problems, questions about health-related quality of life (SF-36), and patient satisfaction. Site investigators and coordinators indicated whether each clinic had instituted a standard alcohol-screening program.

Results: Of 6,788 eligible at-risk drinkers, 3,891 returned the DPQ (57% response). DPQ respondents were primarily male (98%) and Caucasian (62%), with a mean age of 61. The mean AUDIT score was 7.2 with 819 (21%) reporting at least one symptom of dependence in the past year. Among DPQ respondents, 700 (18%) indicated that in the past year they had been advised by their primary care provider to drink less, 661 (17%) had

been advised to quit, and 156 (4%) had received alcohol treatment. Excluding those treated in the past year, a total of 784 (21%) received advice to change their drinking. Advice was more common among patients who were younger, reported less education, were unmarried, had lower income, reported liver disease, or smoked. Among at-risk drinkers who had not received alcohol treatment in the past year, multivariate logistic regression revealed that the following groups were significantly more likely to report *not* receiving any alcohol-related advice in the past year: patients who drank <14 drinks/week (OR 1.99), those without symptoms of alcohol dependence (OR 3.33), those who did not self-report a drinking problem (OR 4.22), those who did not smoke (OR 1.32), and those who reported their health as very good or excellent (OR 1.62). Implementation of clinic-based screening with the CAGE questionnaire was not significantly associated with receipt of advice to modify drinking behavior (OR 1.12) in these at-risk drinkers.

Conclusions: Primary care providers are providing alcohol counseling to less than 25% of at-risk drinkers. Our findings also suggest that primary care providers are more likely to counsel patients with more severe problem drinking. Clinic-based screening alone was not associated with increased counseling of at-risk drinkers.

Impact: While primary care providers appear to be focusing their alcohol counseling on those at-risk drinkers with the most severe problems, the number of patients receiving alcohol counseling continues to be a small proportion of those who might benefit

**Insurance Coverage and Access to Care for
Non-Elderly Veterans**

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Objectives: The objective of this study is to compare insurance coverage and access to care for VA users and non-VA users for veterans under age 65. This study also examined the determinants of being a VA user in the non-elderly veteran population. In addition, this study identified the characteristics of veterans with least access to care.

Methods: Data from the 1996 Medical Expenditures Panel Survey (MEPS) was used to identify veterans under age 65 and their insurance coverage, access to care, demographic characteristics, and employment status. There were 1,353 veter-

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ans under age 65 who were surveyed in MEPS, representing 18 million of non-elderly veterans. Based on the MEPS utilization and expenditure file, we identified VA users as veterans who incurred any VA medical care expenditure in 1996. It is estimated that 3.8 millions of non-elderly used VA services in 1996, accounting for 21% of non-elderly veterans.

Results: Our results indicate that a vast majority of non-elderly veterans had health insurance throughout 1996 (78%), 12% were uninsured in part of 1996, and 12% were entirely uninsured in 1996. The uninsured rate, including both partially and entirely uninsured, for VA users was significantly higher (40%) than non-VA users (18%). In addition, VA users were more likely to be unemployed and to report fair or poor health status than non-VA users, regardless of their insurance status. In addition, uninsured VA users were more likely to have a usual source of care than uninsured non-VA users (77% versus 54%). The non-elderly veterans with least access to care were uninsured non-VA users and had no usual source of care, who were more likely to be single, younger, employed and healthier than the uninsured veterans.

Conclusions: The VA system provides a special safety net for non-elderly veterans, which is not available to most Americans. Most veterans have alternative mechanisms to obtain health care and do not have to rely on the VA as a safety net. This study shows that the VA system does provide a safety net for the most vulnerable non-elderly veterans.

Impact: The results from this study can be used by VA administrators to target specific groups of veterans as new users of VA services, and at the same time further the VA's mission as a health care safety net.

Quality of Life and 5-Year Mortality Among Veterans with Coronary Artery Disease: Results from the Ambulatory Care Quality Improvement Project (ACQUIP) Pilot Study

McDonnell MB, Spertus JA, Fihn SD VA Puget Sound Health Care System, Seattle and University of Missouri, Kansas City

Objective: Measures of patient reported quality of life (QOL) are potentially useful as predictors of outcomes. Few studies, however, have examined the relationship between disease-specific health status and long-term mortality. This study examined the relationship between QOL and all-cause 5- year

mortality among VA outpatients with coronary artery disease (CAD).

Methods: Three VA General Internal Medicine Clinics (Puget Sound Health Care System - Seattle, Boston, and White River Junction, VT) participated in the study as pilot sites for the Ambulatory Care Quality Improvement Project (ACQUIP). This prospective cohort study examined 1679 patients with CAD who responded to QOL surveys mailed between November 1993 and April 1994. Quality of life was measured using 4 scales of the Seattle Angina Questionnaire (SAQ): physical function, disease perception, angina frequency and angina stability. All scales were scored 0 (worst) to 100 (best). Comorbid conditions and demographic information were obtained from a health history completed by patients at entry into ACQUIP. Death information was obtained from local VISTA systems and by linking to the VA Beneficiary Identification and Record Locator System (BIRLS). We included mortality from all causes. Data were examined using survival analysis and Cox Proportional Hazards regression.

Results: The cohort was 98% male and 92% Caucasian with a mean age of 67. Overall, 469 (28%) of the 1679 died during the five year follow-up period. The cumulative proportion surviving at five years was 0.69. Patients were stratified into 2 groups for all scales: those scoring ≤ 50 and those scoring > 50 . The cumulative proportion surviving at 5 years was 0.63 for patients scoring ≤ 50 on the physical scale compared to 0.79 for those scoring > 50 ($p=.000$). For the frequency scale, the cumulative proportion surviving was 0.63 for patients scoring ≤ 50 and .70 for those scoring >50 ($p=.005$). These differences remained significant when stratified by age and co-morbid conditions. Differences in survival were not significant for the disease perception and stability scales. In a multivariate model including physical function, age, and co-morbid conditions, the relative risk of death from all causes was 2.0 (95% CI=1.62-2.46) for patients scoring ≤ 50 compared to those scoring >50 ($p=.000$). In a model including angina frequency, age, and co-morbid conditions, the relative risk of death was 1.4 (95% CI=1.13-1.76) for those scoring ≤ 50 ($p=.003$).

Conclusions: Lower quality of life, as measured by the SAQ physical function and frequency scales, appears to be a significant predictor all-cause mortality in veterans with coronary artery disease. QOL as measured by the disease perception and symptom stability scales did not significantly relate to risk of death.

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Impact: If disease specific QOL instruments such as the SAW can predict mortality, they can potentially be used to identify patients at risk for adverse outcomes. If identified, such patients could benefit from targeted interventions and preventive measures.

A Case Finding Tool to Identify General Internal Medicine Patients with Congestive Heart Failure Using VISTA Pharmacy Data

EM Udris, MB McDonell, DH Au, LC Chen, Wm Tierney, SD Fihn VA Puget Sound Health Care System, Seattle and VAMC Indianapolis, IN

Objectives: An often-overlooked problem with the implementation of computerized clinical practice guidelines is correctly identifying patients to whom the guideline should be applied. The purpose of this study was to develop and validate a computerized tool to identify patients with congestive heart failure (CHF) who would be candidates for management according to a computerized version of a clinical practice guideline.

Methods: We conducted a retrospective cohort study in the General Internal Medicine Clinic at the VA Puget Sound Health Care System, Seattle Division. Subjects having at least one echocardiogram (Echo) or radionuclide ventriculogram between 1996 and 1998 were included. CHF was defined by left ventricular systolic dysfunction (LVSD) on either cardiac study. Subjects were randomly divided into two samples; one for prediction model development and the second for model validation. To determine the utility of clinical data in discriminating between patients with and without CHF, we examined demographic variables, pharmacy data, and inpatient and outpatient primary or secondary ICD-9 codes (428, 398.91) that were available from VISTA. The medications of interest included ACE inhibitors, AII antagonists, beta-blockers, calcium channel blockers, digoxin, diuretics, and nitrates. Discriminant analysis was used to build predictive models to identify patients with LVSD using pharmacy and demographic data. Accuracy of both the prediction model and diagnosis in VISTA were then compared to the presence of LVSD as determined by cardiac imaging.

Results: We identified 1314 subjects who had at least one cardiac imaging study. 536 (40.8%) subjects met study criteria for LVSD. The mean age

was 68, 84% were Caucasian, and 97% males. Subjects with LVSD were slightly older than subjects without LVSD (69 versus 67, $p=0.004$), but were similar with regard to gender, race and marital status. Subjects with LVSD were more likely to have prescriptions for ACE inhibitors, aspirin, digoxin, loop diuretics, hydralazine and nitrates. (Carvedilol was not on formulary during the study period.) ACE inhibitors, aspirin, digoxin, loop diuretics, hydralazine, nitrates and age were included in the final predictive model. Use of ACE inhibitors, loop diuretics and digoxin exerted the greatest predictive power. The predictive model was 70% accurate (72% sensitivity, 69% specificity), while ICD-9 codes were 72% accurate (74% sensitivity, 71% specificity).

Conclusions: A model using pharmacy data identified most subjects with CHF, and performed equally well compared to ICD-9 codes in VISTA. Although the model did not demonstrate improvement over ICD-9 codes, it was able to predict LVSD using a relatively small number of the potential covariates. Considering that limited covariates were used for this study, the possibility for model refinement is considerable.

Impact Statements: Before computerized guidelines can be effectively implemented, accurate methods of identifying patients must be developed. Although heart failure is the most common diagnosis in hospital subjects age 65 years and older, the clinical recognition and treatment of heart failure remains a difficult problem. Sub-optimal patient care can occur when CHF is unrecognized or misclassified. Whether misclassification occurs as a result of data errors in the clinical information system or clinician judgment, lack of recognition may adversely impact patient care and case-mix adjustment.

My Kidney Transplant

by Monica Hayes

Three months ago, I was blessed with the gift of life; a kidney donated to me by my nephew Matt. My story is not so unusual in this day and age of advanced technology, enlightenment by organ donors and the incredible talents of medical professionals. But I wanted to share my story with you as my colleagues and friends.

Working for Health Services Research and Development (HSR&D) has been a great experience and I've certainly learned much about research and especially how difficult it is to keep up with new and state-of-the-art technologies. Another challenge is the ever-changing merit review submission requirements; human subjects confidentiality issues, data management, access and security concerns; and dealing with budget issues. But the most enjoyable aspect of being here at the Seattle COE, is working with the investigators and being instrumental in assisting them with their projects, either in the formulation stages, or after they've been funded. The challenge then continues with recruitments, finding office space, and getting the projects off the ground.

I've worked for the HSR&D Center of Excellence for 11 years, giving me a total of 18 years federal government service. The other seven years I worked for the Army and Navy at various locations around the world. In 1978 I decided I needed a hiatus from government service and found employment in the film industry. That was a great job! Movie screenings during the workday, and movie screenings in the evenings. A tough job, but as they say, someone had to do it. In 1980 I was able to transfer from the San Francisco branch of Paramount Pictures to their Seattle office. After Paramount closed their branch offices in the late 80's, I resumed federal employment and came to work for the Seattle VA Medical Center.

My husband of *five* years and I have a total of 8 grandchildren – all boys! Obviously, I had nothing to do with that! Besides the joy of grandparent-hood, we love to hike, volunteer with our church, and work with the local theatre group.

I have been a type I, insulin-dependent diabetic for 36 years. I've had all the “text book” complications from this disease: stillbirth, retinopathy, neuropathy, nephropathy, coronary artery disease. For 10 years I'd watched my creatine level (test for kidney function) rise slowly and steadily, making end stage renal disease (ESRD) or total renal failure the next reality. I tried to ignore the acronym mentioned periodically by my nephrologist in the 1980's and concentrate on trying to keep my diabetes in tight control. But according to him, ESRD was inevitable. It didn't matter how I managed my diabetes; it “was just a matter of time.”

And the time came in 1999. My creatine level was hovering between 6-7 (acceptable levels are 1-5, one being good). My choices were either kidney dialysis or kidney transplant. So I bit the bullet and made a visit to the NW Kidney Center in Seattle. I discussed my dialysis options with the great nursing staff there, and decided which way I wanted to spend the rest of my life keeping my system free of the potentially fatal toxins. Being very active, working full-time, and wanting to travel and not “have” to be at a kidney center hooked into a machine for three to five hours, three times a week, I decided to go with peritoneal dialysis instead of hemodialysis. Because of the freedoms CAPD (continuous ambulatory peritoneal dialysis) afforded me, I decided that CAPD was definitely the way to go.

I interviewed at Virginia Mason Hospital in Seattle with my current nephrologist, Dr. Catherine Thompson and my surgeon, Dr. Thomas Hefty. They decided, even at the age of 52 and with all my other complications, I could be a candidate for a kidney transplant. I was put on the cadaver kidney transplant list. The other organ transplant option was a living donor. Who would be willing to make that commitment?

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Northwest HSR&D Center of Excellence

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HSR&D Deadlines

Local deadline for proposal review is two weeks prior to Research Review Committee meeting and two months prior to VAHQ deadline. Review Committee meets on 1st Friday of each month.

VAHQ Deadlines

Letters of Intent (LOI): Accepted any time, reviewed monthly. Guidelines in Instructions for Submitting a Letter of Intent, January, 2000.

Investigator-Initiated Research Proposals (IIR): Due May 1 and November 1. An approved LOI is required prior to submission. Guidelines in Instructions for Preparing Investigator-Initiated Research Proposals, October, 1997.

Research Career Scientist: March 1 and September 1. Guidelines in RCS Directive VHA Notice 98-02.

Career Development: Due February 15 and August 15. Must have approved LOI prior to submission; due November 1 and May 1. Guidelines in CDA Directive VHA 1201.8.

For current guidelines and forms, please refer to www.va.gov/resdev.

HSR&D Newsletter

The Northwest HSR&D COE Newsletter is published periodically. Contributions for publication should be sent to:

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My Kidney Transplant, by Monica Hayes

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Even before I actually began the dialysis, my husband Mike Bishop insisted that he could be a match and was tested for his compatibility as a kidney donor. After a month or two, and several tests later, it was determined that we were compatible in every other way but that. So Mike had to step aside and forego that ultimate precious gift to me.

I then gathered my immediate family around me and tearfully told them what was in store for me. I put no pressure on them even though they were my best hope. My two sisters had their blood tests done immediately. And as it turned out neither had the same blood type. I felt I had no more options so I went ahead and started the CAPD. I figured I would just await a cadaver kidney, no matter how long it took.

But miracles happen. Matt, my sister's 27 year old son overheard his mother and aunt talking about my situation, so he took it upon himself to get his blood tested. He wasn't even asked. I was shocked that he would consider it. We'd had a rocky relationship; and I didn't have much faith in his ability or willingness to make such a commitment.

After many telephone calls, tests, and re-tests, we soon found out that he was a 50% match (close as a brother or sister). Finally, he was declared healthy enough and my suitable match. Surgery was scheduled for 12/1/99. I was getting my Christmas gift early. We were going for transplant!

The surgeries went very well, no serious complications to report. During this time, we had some great talks, and learned a little more about each other. That's what happens when you can't move very far or very fast. We now have a greater understanding of each other and I am so grateful to him for his selfless sacrifice. I also hadn't realized how sick I was until after the transplant. I feel much better now and I'm full of this incredible energy.

Matt is back in school making a career change; and I have my life back to do the things I love. It was difficult to even work in the garden, or go for a walk when I was on dialysis four times a day and working full-time because of all the time it took. Now I can travel, work, play, get serious without the burden of dialysis.

I think we both got something from this time in our lives besides sharing the surgical experiences. Our gifts to each other in December cannot be measured. They cannot be looked at, admired, nor taken back to the store. So precious is the gift of life.

For information on becoming an organ donor, myths about organ donations, resources and links - go to www.organdonor.gov